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| METRO HOMES, INC | 615 55TH STREET, NE WASHINGTON, DC 20019 |

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| W 000 | INITIAL COMMENTS | W 000 | | |

The Health Regulation Licensing Administration (HRLA) received a referral via facsimile from the Department of Disabilities Administration (DDA) on March 19, 2009, submitted by the University Legal Services (ULS) monitoring team. The attached report dated March 13, 2009 reflected findings of an on-site visit conducted on Sunday, March 8, 2009 and a previously conducted monitoring visit on September 28, 2008. As the result of the on-site visits, ULS filed a report alleging that identified "Evans Class" members were at risk due to staff members on how to implement client mealtime/positioning protocols. The visits also noted that staffing ratios were inadequate; limited individualized activities were offered and inadequate community outings. The nature of the allegations was defined as:

(a) Staff to resident ratios are not adequate;

(b) Staff does not implement feeding protocols adequately. One class member displayed a significant cough throughout the meal;

(c) Staff have limited knowledge of the class members' significant health risks;

(d) Staff are not adequately implementing position protocols;

(e) Staff are not adequately monitoring fluid intake;

(f) Staff does not administer medication according to protocol;

(g) Staff does not offer meaningful, individualized activities;

Received 5/4/09

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION
825 NORTH CAPITOL ST., N.E., 2ND FLOOR
WASHINGTON, D.C. 20002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sloan J. Sloan RN, BSN, MA | TITLE: VP Operations | (X6) DATE: 4/30/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(h): The clients are not being provided adequate community outings; and

(i) Trash was observed in the yard and a car was parked on the lawn.

A combination investigation/ recertification survey was initiated on March 26, 2009 through March 28, 2009 utilizing the full survey process. A random sample of three clients was selected from a population of six males with various degrees of disabilities.
The findings were based on observations at the group home and two day programs, interviews with clients, group home direct care staff, and administrative staff, and review of client and administrative records; including incident reports. As a result of the findings, it was determined that the facility was in compliance with the Conditions of Participation and local standards, however standard level deficiencies were cited. The following two of the nine concerns identified by ULS were substantiated as follows:

Staff were not adequately monitoring fluid intake; and

Staff were not administering medication according to protocol.

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| W 159 | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL | W 159 | | |

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by:

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| W 159 | Continued From page 2<br>Based on interview and record review, the Qualified Mental Retardation Professional [QMRP] failed to ensure the coordination of services for four of six clients residing in the facility. [Clients #1, #2, #3 and #5]<br><br>The findings include:<br><br>1. The QMRP failed to ensure that #2's adaptive equipment was maintained in good repair. [See W436]<br><br>2 The QMRP failed to ensure Client #5 received food in the texture recommended in his mealtime protocol. [See W192, W331 ]<br><br>3. The QMRP failed to ensure Client #2's day program was made aware of modifications in the use of an adaptive cup.<br><br>Observation during the lunch mealtime on March 26, 2009 at approximately 12:00 PM revealed that Client #2 was served his prescribed diet in a divided plate utilizing, with hand over hand assistance, a built-up left angle coated spoon. Further observation revealed that Client #2 drank his beverage from an open handled dysphasia cup. According to the day program staff, the adaptive equipment was supplied by the group home. When questioned about the use of a spout cup observed during the breakfast mealtime observation earlier that day, the day program staff reported that they were instructed to utilize the dysphasia cup.<br><br>Upon return to the group home at approximately 2:45 PM the QMRP was interviewed. She indicated that they had been instructed in the past to utilize the dysphasia cup, however, currently | W 159 | W 159<br>1. The individual's wheelchair – tilt mechanism has not been fixed yet. The parts have been ordered by Essential Rehab and have not been delivered yet.<br>However the staff continues to reposition him outside of his wheelchair – see attached positioning record and letter from Essential Rehab.<br>2. All staff were re trained in the correct consistency for the liquid – honey thick consistency. In the future the QMRP and RN will ensure that all staff are compliant with the recommended mealtime protocol, by monitoring the staff during mealtimes at least weekly and documenting meal intake.<br>3. The QMRP and the RN have corrected the POS to include the order for a 'handled spouted cup' for liquids. Acup has been sent to the day program along with a POS. | |

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| W 159 | Continued From page 3<br>had been instructed to use the spout cup. Review of the speech therapist assessment dated July 27, 2008 on March 26, 2009 at 4:00 PM indicated that he presents mild to moderate dysphagia and recommended the use of the dysphasia cup, however review of the July 22, 2008 nutrition assessment and the July 29, 2008 occupational therapy assessment at 4:15 PM revealed both recommended the use of a spout cup. Review of the July 22, 2008 mealtime protocol indicates to use a "handled mug". Although both cups utilized were handled mugs, it was unclear as to which adaptive equipment cup( spouted or unspouted) was to be utilize to ensure safe and adequate dietary intake.<br><br>4. On March 26, 2009 at 12:35 PM, Client #3 was being prepared for lunch. The staff placed pillows on both sides of his wheelchair, and replaced his blue neck support with a pillow. During the breakfast observation earlier that day, the staff were observed to position one pillow on the left side of his chair, with the blue neck support in place. He was positioned upright throughout the entire meal in his wheelchair and did not exhibit any meal time coughing.<br><br>On March 27, 2009 at approximately 3:30 PM the facility's physical therapist was interviewed about Client #3's wheelchair status and the use of the pillows. According to the Physical therapist, during the interim, until his new wheelchair arrives, staff are to be consistent with the use of one pillow place on one side of his wheelchair and the use of the blue neck support during mealtimes. He further indicated that the blue neck support would allow more flexibility than a pillow to safety flex his neck back for oral intake. Interview with the QMRP indicated that she would | W 159 | 4. This individual has a new wheelchair and does not require any use of pillows to assist with his positioning.<br>In the future the QMRP and RN will ensure that all staff are compliant with the recommended mealtime protocol, by monitoring the staff during mealtimes at least weekly and documenting meal intake. | 4/30/09 |

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| W 159 | Continued From page 4<br>visit the day program to ensure consistency. | W 159 | W192 | |
| W 192 | 483.430(e)(2) STAFF TRAINING PROGRAM<br><br>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to effectively train the Trained Medication Employee (TME) and the direct care staff on the prescribed liquid consistency for one of one client, that required modifications to the consistency of his liquids. (Client #5)<br><br>The findings include:<br><br>1. (Cross refer to W331) On March 26, 2009 at approximately 8:50 AM, Client #5 was being administered his medication. The client's medications were crushed and placed in apple sauce. He received a thin consistency juice from a spout cup after he consumed the medication/applesauce mixture. Review of the client's feeding protocol on the same day at approximately 3:30 PM, revealed that the client was to receive honey consistency liquids. Interview with the facility's nurse on March 26, 2009, during the evening medication administration, acknowledged that the client's liquids given at medication administration should have been a honey consistency, further demonstrating the required texture for consumption prior to receiving his medications.<br><br>The facility's TME, however failed to provide honey thickened liquid to the client during the | W 192 | 1. All TMEs were re in-serviced on the Policy and Procedures for medication administration, mealtime protocols and safety procedures for medication administration. In the future the RN will ensure that all TMEs are adequately in-serviced on dietary orders and the mealtime protocols as well as the medications and a complete review of the POS is completed for each individual.<br>2. All staff were in-serviced by the RN on the individual's mealtime protocol and the procedure to use Thick it to obtain the ordered consistency. In the future the QMRP and RN will ensure that all staff are compliant with the recommended mealtime protocol, by monitoring the staff during mealtimes at least weekly and documenting meal intake. | 4/30/09 |

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| W 192 | Continued From page 5<br>medication administration.<br><br>2. On March 26, 2009, at approximately 7:20 AM a direct care staff was observed assisting Client #5 with his breakfast meal. The staff informed the the surveyor that Client #5's liquids required a thickener. The staff person was observed to place three tablespoons of thickner into a full spout cup with water. She shook it briefly to mix it and assisted the client, by holding his cup as he consumed his beverage. The texture of the water however, remained thin. Review of Client #5's mealtime protocol revealed he was to receive honey consistency liquids.<br><br>Interview with the facility nurse on March 26, 2009 at approximately 4:30 PM verified that the liquid texture should be thick, like honey, and that 3 scoops were accurate. The nurse presented the thickner can to the surveyor and pointed out honey textures-3 scoops per 4 ounces of liquid. The nurse further indicated that she had recently trained all staff on the correct texture on March 21, 2009, but indicated that there was no sign in sheet. An evening staff was present at that time of the discussion and stated that she had participated in the training. When questioned about the amount of thickner to use, she stated "1-6 scoops". At approximately 4:50 PM, the direct care staff person preparing the evening meal was questioned about the size of the cup used at mealtimes. He stated that the spout cup holds ten ounces of liquids and that at least 8 scoops should have been used to obtain the honey consistency. The facility failed to effectively train all staff on how to provide the appropriate beverage consistency for Client #5. | W 192 | | |
| W 242 | 483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN | W 242 | | |

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| W 242 | Continued From page 6<br>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure that one of three clients in the sample received training in hand washing to the extent of their capability. (Client #1)<br><br>The finding includes:<br><br>On March 26, 2009 at approximately 5:20 PM, Client #1 was in the activity room of the facility. The House Manager (HM) placed a device that made different nature sounds on the lap tray of his chair and encouraged the client to push the buttons with his hand to change the sounds. He was observed placing his fingers in his mouth at times during this observation. At approximately 5:35 PM, Client #1 was transported to the dining area for his snack. Prior to the client reaching the dining area and receiving his snack, the staff did not wash his hands.<br><br>Review of his Mealtime Protocol (dated December 23, 2008) reflected that the staff should " Help [Client name] to wash his hands and nails thoroughly prior to each meal."<br><br>According to the review of the Individual Support Plan dated February 2008, the client required | W 242 | W242<br>The QMRP and the RN have retrained all the staff on infection control. The QMRP has initiated a hand washing program – see attached<br>In the future the QMRP and RN will ensure that all staff receive training which is necessary to provide safety and will include programs appropriate to the individual's needs.<br>See attached training – infection control and IPP for hand washing | 4/30/09 |

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| W 242 | Continued From page 7<br>staff assistance with activities of daily living. The IPP failed to identify programs to address the clients needs. There was no evidence of a training program in this area. | W 242 | | |
| W 247 | 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN<br><br>The individual program plan must include opportunities for client choice and self-management.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the clients were afforded an opportunity to choose their snacks for six of six clients that reside in the facility. (Client's #1, #2, #3, #4, #5, and #6)<br><br>The finding includes:<br><br>The facility failed to ensure each staff provided opportunities for client choice as detailed below:<br><br>On March 26, 2009, at approximately 5:45 PM, the clients received their afternoon snack. All of the clients were served chocolate pudding. At no time during the observation were the clients offered a choice between the pudding and another snack. The Qualified Mental Retardation Professional (QMRP), House Manager (HM) and the Licensed Practical Nurse (LPN) were informed of the observation. Further interview with the QMRP at 6:00 PM acknowledged the lack of choices offered to the clients. | W 247 | W247<br>All staff were in serviced on client's rights and choices.<br>In the future the QMRP and RN will ensure that all staff are compliant with the recommended mealtime protocol, by monitoring the staff during mealtimes at least weekly and documenting meal intake and client's choices. | 4/30/09 |
| W 261 | 483.440(f)(3) PROGRAM MONITORING & CHANGE<br><br>The facility must designate and use a specially constituted committee or committees consisting | W 261 | | |

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| W 261 | Continued From page 8<br>of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview, and record review, the facility failed to designate and use a specially constituted committee, the Human Rights Committee (HRC) that included persons with no ownership or controlling interest in the facility for one of three clients in the sample. (Client #1)<br><br>The finding includes:<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) on March 26, 2009 during the entrance conference revealed that HRC meetings had been conducted to discuss behavior support plans, unusual incidents and the use of restrictive procedures for Client #1. On December 3, 2008, Client #1's Emergency room visits, the use of the Geriatric Chair with a safety harness and the need for sedation (Ativan 2mg) for a CT scan were reviewed and approved. Review of the HRC signature sheet for the aforementioned date on March 28, 2009 at approximately 1:45 PM revealed no evidence that persons with no ownership or controlling interest were included in the HRC approval.<br><br>Interview with the House Manager (HM) on March 28, 2009, at approximately 2:00 PM, acknowledged the lack of a community representative present during the meeting. | W 261 | W261<br>For that particular month the community rep. was unable to attend the meeting and reported her unavailability only an hour or two before the scheduled meeting. However the meeting minutes were sent to her for her approval or disapproval<br>Metro Homes, Inc. has coupled with another similar agency for the Human Rights Committee since March 2009 and will ensure that community representation is included for every meeting. | 4/30/09 |
| W 322 | 483.460(a)(3) PHYSICIAN SERVICES | W 322 | | |

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| W 322 | Continued From page 9<br><br>The facility must provide or obtain preventive and general medical care.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure general and preventative care services, for two of three clients in the sample (Clients #2 and #3), to include one client not in the sample (client #5)<br><br>The findings include:<br><br>1. During the medication pass observation on March 26, 2009, starting at approximately 8:15 AM revealed all of the clients with the exception of Client #5 received lactulose. Interview and record review revealed that the medication was given for constipation. Review of client #2, #3 and #5's Mealtime Protocols reflected that the staff was instructed to encourage fluid intake. The clients were observed receiving fluids throughout the survey, both in the home and at their day programs. Review of the Fluid Intake Records on March 28, 2009 at approximately 11:00 AM, revealed that the staff were not consistently documenting the fluid intake.<br><br>According to a complaint made by the University Legal Services (ULS), dated March 13, 2009; a visit was made to the facility on March 8, 2009. The ULS monitor observed the same discrepancies in what was observed versus what was documented. The record for that day (March 28th) failed to have documentation of the amount of fluids the clients consumed for breakfast and lunch. | W 322 | W322<br>1. refer to W159 #2<br>2. The RN and LPN have corrected the physician's order and the individual is on an 1800 cal diabetic, high fiber pureed diet. In the future the RN will ensure that all consultant recommendations and the medical records are reviewed monthly during the QA process so as to deter a recurrence of this.<br>3. The QMRP has retrained all the staff on the individual's mealtime protocol.<br>In the future the QMRP and RN will ensure that all staff are compliant with the recommended mealtime protocol, by monitoring the staff during mealtimes at least weekly and documenting meal intake. | 4/30/09 |

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| W 322 | Continued From page 10 | W 322 | | |

Review of the facility's training records, in response to the March 13, 2009 ULS complaint, on March 27, 2009 at approximately 10:30 AM, reflected the facility conducted in service training with the staff on March 23, 2009. Based on observations by the ULS and survey team, the facilities training was ineffective. The administrative staff was made aware of the observations and findings on March 28, 2009.

2. Review of Client #2's July 22, 2008, nutrition assessment on March 27, 2009 at 9:40 AM revealed a recommendation to change the client's diet order to an 1800 Kcals Diabetic, High Fiber, Pureed from Low Cholesterol, no concentrated sweets (NCS), Pureed diet. Review of the physician order dated January 9, 2009 reflected a telephone order to change diet to 1800 diabetic high fiber pureed, six months later. Interview conducted with the facility nurse at 9:50 AM verified that the diet order had not been changed as prescribed. There was no evidence that the recommendation for the diet change had been addressed at the time of the survey.

3. During the breakfast mealtime observation conducted on March 26, 2009 at 7:20 AM, staff were observed feeding Client #3 his breakfast. Water was given throughout the meal and after every two to three bites, to help clear food from his mouth. Upon completion of his meal, a review of his March 10, 2009, Feeding protocol revealed that he was to receive a supplement; Prune juice 1/2 cup, twice a day. (Breakfast and Dinner). At no time during the breakfast meal was he offered the prune juice.

Review of Client #3's medical record and March

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| W 322 | Continued From page 11<br>2009 Physician orders on March 26, 2009, at 2:30 PM, revealed that he was prescribed colace liquid 10ml (100 mg) twice daily and Lactulose 30 ml daily for constipation. | W 322 | | |
| W 331 | 483.460(c) NURSING SERVICES<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure the prescribed liquid texture was provided during the medication pass for one of one client that require a modified liquid texture. (Client #5)<br><br>The finding includes:<br><br>On March 26, 2009, at approximately 8:50 AM, the Trained Medication Employee (TME) was observed administering medication to Client #5. The client's medications were crushed and placed in apple sauce. He received a thin consistency juice from a spout cup after he consumed the medication/applesauce mixture. Review of the client feeding protocol on the same day at approximately 3:30 PM, revealed the client was to receive honey consistency liquids. Interview with the facility's nurse on March 26, 2009, acknowledged that the client's liquids should be a honey consistency. The facility's TME, however failed to provide honey thickened liquid to the client during the medication administration. | W 331 | W331<br>All staff were re trained in the correct consistency for the liquid – honey thick consistency. In the future the QMRP and RN will ensure that all staff are compliant with the recommended mealtime protocol, by monitoring the staff during mealtimes at least weekly and documenting meal intake. | 4/30/09 |
| W 369 | 483.460(k)(2) DRUG ADMINISTRATION<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. | W 369 | | |

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| W 369 | Continued From page 12<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview, and record verification, the facility failed to ensure medications were administered as prescribed for one of the three clients in the sample. (Client #1)<br><br>The finding includes:<br><br>On March 26, 2009 at approximately 8:15 AM, the Trained Medication Employee (TME) was observed to administer Client #1 his medication. Among the medications given was Lactulose 30 cc's. The Physician's Order's (dated March 1, 2009) was reviewed, to verify the medication pass observation, on March 27, 2009 at approximately 11:00 AM. The order reflected that the lactulose was prescribed " every four days for constipation. " Review of the Medication Administration Record (MAR) on the same day revealed that the days the medication were to be administered were indicated by a box drawn around the respective date. The date blocked off for the medication to be administered was March 27, 2009, however the medication was observed being administered on March 26, 2008. | W 369 | W369<br>All TMEs were re in-serviced on the Policy and Procedures for medication administration and documentation, mealtime protocols and safety procedures for medication administration. In the future the RN will ensure that the system of monthly monitoring of the TME during med pass is completed and appropriate correction and teaching is done at the time to avert any recurrence. | 4/30/09 |
| W 436 | 483.470(g)(2) SPACE AND EQUIPMENT<br><br>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.<br><br>This STANDARD is not met as evidenced by: | W 436 | | |

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| W 436 | Continued From page 13<br>Based on observation, interview and record review, the facility failed to ensure that each client's adaptive equipment was maintained in good repair and clients were taught to use and to make informed choices about the use of the devices one of the three clients in the sample. (Client #2)<br><br>The finding includes:<br><br>Interview with the Qualified Mental Retardation Professional (QMRP) on March 26, 2009 at 4:50 PM revealed that client #2's was to be repositioned daily by staff, every two hours in his wheelchair by utilizing a tilt mechanism. At approximately 4:52 PM the QMRP was asked to demonstrate the use of the tilting mechanism. It was observed that the wheelchair was missing the left handle on the back of the seat, rendering the chair's tilting capability inoperable. The QMRP was not able to tilt the chair.<br><br>Review of the client's record on March 27, 2009 at 9:40 AM verified that he was to be repositioned every two hours. Later interview with the facility's physical therapist that same day at 4:15 PM revealed that repairs to his wheelchair had been completed earlier in the day (replaced foot box), however the tilt mechanism remained on order. He indicated that although the client was capable to reposition himself while in the wheelchair, the tilting mechanism allowed more adequate repositioning options to maintain his skin integrity. | W 436 | W436<br>The individual's wheelchair – tilt mechanism has not been fixed yet. The parts have been ordered by Essential Rehab and have not been delivered yet.<br>However the staff continues to reposition him outside of his wheelchair – see attached positioning record and letter from Essential Rehab. The QMRP will continue to ensure that the staff reposition and document repositioning as per the system in place – see attached positioning record | 4/30/09 |
| W 455 | 483.470(l)(1) INFECTION CONTROL<br><br>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. | W 455 | | |

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| W 455 | Continued From page 14<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to implement infection control techniques as outlined in the feeding protocol for one of three clients in the sample (Client #1)<br><br>The finding includes:<br><br>On March 26, 2009 at approximately 5:20 PM, Client #1 was in the activity room of the facility. The House Manager (HM) placed a device that made different nature sounds on the lap tray of his chair and encouraged the client to push the buttons with his hand to change the sounds. He was observed placing his fingers in his mouth at times during this observation. At approximately 5:35 PM, Client #1 was transported to the dining area for his snack. Prior to the client reaching the dining area and receiving his snack, the staff did not wash his hands. Review of his Mealtime Protocol (dated December 23, 2008) reflected that the staff should " Help [Client name] to washed his hands and nails thoroughly prior to each meal." The house manager, Qualified Mental Retardation Professional was made aware of this observation on March 30, 2009. | W 455 | W455<br>Refer to W242 | |
| W 474 | 483.480(b)(2)(iii) MEAL SERVICES<br><br>Food must be served in a form consistent with the developmental level of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to ensure that one of six (#5) clients residing in the facility received food in a form consistent with his developmental level. | W 474 | W474<br>Refer to W331 | |

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| W 474 | Continued From page 15<br>(Client #5)<br><br>The finding includes:<br><br>Cross refer to W192 and W331. The facility failed to ensure Client #5 received his beverages in the consistency prescribed. (Honey textured) | W 474 | | |

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| I 000 | INITIAL COMMENTS<br><br>The Health Regulation Licensing Administration (HRLA) received a referral via facsimile from the Department of Disabilities Administration (DDA) on March 19, 2009, submitted by the University Legal Services (ULS) monitoring team. The attached report dated March 13, 2009 reflected findings of an on-site visit conducted on Sunday, March 8, 2009 and a previously conducted monitoring visit on September 28, 2008. As the result of the on-site visits, ULS filed a report alleging that identified "Evans Class" members were at risk due to staff members on how to implement client mealtime/positioning protocols. The visits also noted that staffing ratios were inadequate; limited individualized activities were offered and inadequate community outings. The nature of the allegations was defined as:<br><br>(a) Staff to resident ratios are not adequate;<br><br>(b) Staff does not implement feeding protocols adequately. One class member displayed a significant cough throughout the meal;<br><br>(c) Staff have limited knowledge of the class members' significant health risks;<br><br>(d) Staff are not adequately implementing position protocols;<br><br>(e) Staff are not adequately monitoring fluid intake;<br><br>(f) Staff does not administer medication according to protocol;<br><br>(g) Staff does not offer meaningful, individualized activities; | I 000 | | |

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| I 000 | Continued From page 1<br>(h): The clients are not being provided adequate community outings; and<br><br>(i) Trash was observed in the yard and a car was parked on the lawn.<br><br>A combination investigation/ recertification survey was initiated on March 26, 2009 through March 28, 2009 utilizing the full survey process. A random sample of three clients was selected from a population of six males with various degrees of disabilities.<br>The findings were based on observations at the group home and two day programs, interviews with clients, group home direct care staff, and administrative staff, and review of client and administrative records; including incident reports. As a result of the findings, it was determined that the facility was in compliance with the Conditions of Participation and local standards, however standard level deficiencies were cited. The following two of the nine concerns identified by ULS were substantiated as follows:<br><br>Staff were not adequately monitoring fluid intake; and<br><br>Staff were not administering medication according to protocol. | I 000 | | |
| I 223 | 3510.4 STAFF TRAINING<br><br>Each training program agenda and record of staff participation shall be maintained in the GHMRP and available for review by regulatory agencies.<br><br>This Statute is not met as evidenced by:<br>Based on review of staff training records and personnel records, the GHMRP failed to make available agendas with documented staff | I 223 | I 223<br>All staff were in serviced again in repositioning, fluid intake, medication administration, bedside swallowing, leisure/recreation and active treatment.<br>In the future, the QMRP, RN and Residential Coordinator will ensure that all staff will receive the necessary in-service training to equip them to care for the individuals.<br>See attached – in-service training records | 4/30/09 |

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| I 223 | Continued From page 2<br>in-service training on seven of seven training's reviewed.<br><br>The finding includes:<br><br>Review of the staff in-service training book on March 28, 2009, at approximately 2:30 PM revealed that not all training activities contained the agenda outlining the content. (Accurate documentation, Repositioning, fluid intake, medication administration, Bedside swallowing, leisure/recreation and Active Treatment) | I 223 | | |
| I 291 | 3514.2 RESIDENT RECORDS<br><br>Each record shall be kept current, dated, and signed by each individual who makes an entry.<br><br>This Statute is not met as evidenced by:<br>Based on observation and record review the GHMRP failed to ensure its primary care physician (PCP) dated entries made in the medical record for three of three residents in the sample. (Resident #1, #2, and #3)<br><br>The finding includes:<br><br>Review of Resident #1 ' s medical record on March 26, 2009 and March 27, 2009 revealed the client received laboratory services and evaluations from several consultants. Although the PCP initialed the documents indicating the she had reviewed the documents, it could not be determined if the documents were reviewed timely because the PCP did not date the entries. Further reviews conducted on Resident #2 and #3's medical records on the same days evidenced the same findings. | I 291 | I291<br>In the future the nursing staff will ensure that all documents reviewed by the PCP will be initialed and dated, to show the reviews were completed in a timely manner. | 4/30/09 |

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| I 423 | Continued From page 3 | I 423 | I423 | |
| I 423 | 3521.4 HABILITATION AND TRAINING<br><br>Each GHMRP shall monitor and review each resident ' s Individual Habilitation Plan on an ongoing basis to ensure participation of the resident and appropriate GHMRP staff in revision of such Plans whenever necessary. The schedule for the reviews shall be documented within each IHP.<br><br>This Statute is not met as evidenced by:<br>Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for three of three residents in the sample (Residents #1, #2 and #3) and one resident not in the sample. (Resident #5)<br><br>The findings include:<br><br>1. The QMRP failed to ensure that the resident #2's adaptive equipment was maintained in good repair. [ See Federal Deficiency Report-Citation W436]<br><br>2 The QMRP failed to ensure resident #5 received food in the texture recommended in his mealtime protocol. [See Federal Deficiency Report-Citation W192 and W322]<br><br>3. The QMRP failed to coordinate services with Resident #2's day program to ensure the use of adaptive equipment during mealtimes as evidenced by:<br><br>Observation during the lunch mealtime on March 26, 2009 at approximately 12:00 PM revealed that Resident #2 was served his prescribed diet in a divided plate utilizing, with hand over hand | I 423 | 1. The individual's wheelchair – tilt mechanism has not been fixed yet. The parts have been ordered by Essential Rehab and have not been delivered yet.<br>However the staff continues to reposition him outside of his wheelchair – see attached positioning record and letter from Essential Rehab. The QMRP will continue to ensure that the staff reposition and document repositioning as per the system in place – see attached positioning record<br>2. All staff were in-serviced by the RN on the individual's mealtime protocol and the procedure to use Thick it to obtain the ordered consistency.<br>In the future the QMRP and RN will ensure that all staff are compliant with the recommended mealtime protocol, by monitoring the staff during mealtimes at least weekly and documenting meal intake. | |

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| I 423 | Continued From page 4<br>assistance, a built-up left angle coated spoon. Further observation revealed that Resident #2 drank his beverage from an open handled dysphasia cup. According to the day program staff, the adaptive equipment was supplied by the group home. When questioned about the use of a spout cup observed during the breakfast mealtime observation earlier that day, the day program staff reported that they were instructed to utilize the dysphasia cup.<br><br>Upon return to the group home at approximately 2:45 PM the QMRP was interviewed. She indicated that they had been instructed in the past to utilize the dysphasia cup, however, currently was changed to a spout cup. Review of the speech therapist assessment dated July 27, 2008 indicated that Resident #2 presents mild to moderate dysphagia and recommended the use of the dysphasia cup, however review of the July 22, 2008 Nutrition assessment and July 29, 2008 Occupational Therapy assessment, both recommended the use of a spout cup. Review of the mealtime protocol indicates to use a "handled mug". Although both cups utilized were handled mugs, it was unclear as to which adaptive equipment cup( spouted or unspouted) was to be utilize to ensure safe and adequate dietary intake.<br><br>4. On March 26, 2009 at 12:35 PM, Resident #3 was being prepared for lunch at the day program. The staff placed pillows on both sides of his wheelchair, and replaced the blue neck support with a pillow. However during the breakfast observation earlier that day, the staff were observed to position one pillow on the left side of his chair, with the blue neck support in place. He was positioned upright throughout the entire meal in his wheelchair and did not exhibit any meal time coughing. | I 423 | 3. The QMRP and the RN have corrected the POS to include the order for a 'handled spouted cup' for liquids. A cup has been sent to the day program along with a POS.<br>4. This individual has a new wheelchair and does not require any use of pillows to assist with his positioning. | 4/30/09 |

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| I 423 | Continued From page 5<br><br>On March 27, 2009 at approximately 3:30 PM the facility's physical therapist was interviewed about Resident #3's wheelchair status and the use of the pillows. According to the Physical therapist, during the interim, until his new wheelchair arrives, staff are to be consistent with the use of one pillow place on one side of his wheelchair and the use of the blue neck support during mealtimes. He further indicated that the blue neck support would allow more flexibility than a pillow to safety flex his neck back for oral intake. Interview with the QMRP indicated that she would visit the day program to ensure consistency. | I 423 | | |
| I 432 | 3521.7(c) HABILITATION AND TRAINING<br><br>The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:<br><br>(c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care);<br><br>This Statute is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to ensure that one of three residents in the sample received training in hand washing to the extent of their capability. (Resident #1)<br><br>The finding includes:<br><br>On March 26, 2009 at approximately 5:20 PM, Resident #1 was in the activity room of the facility. The House Manager (HM) placed a device that made different nature sounds on the lap tray of his chair and encouraged the client to push the buttons with his hand to change the sounds. He was observed placing his fingers in | I 432 | I432<br>The QMRP and the RN have retrained all the staff on infection control. The QMRP has initiated a hand washing program – see attached<br>In the future the QMRP and RN will ensure that all staff receive training which is necessary to provide safety and will include programs appropriate to the individual's needs.<br>See attached training – infection control and IPP for hand washing | 4/30/09 |

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| I 432 | Continued From page 6<br>his mouth at times during this observation. At approximately 5:35 PM, Resident #1 was transported to the dining area for his snack. Prior to the client reaching the dining area and receiving his snack, the staff did not wash his hands.<br><br>Review of his Mealtime Protocol (dated December 23, 2008) reflected that the staff should " Help [Resident name] to washed his hands and nails thoroughly prior to each meal."<br><br>According to the review of the Individual Support Plan dated February 2008, the resident requires staff assistance with activities of daily living. The IPP failed to identified programs to address the residents needs. There was no evidence of a training program in this area. | I 432 | | |